THE STATE OF NEW HAMPSHIRE

CHILD FATALITY REVIEW COMMITTEE

ELEVENTH ANNUAL REPORT

Presented to
The Honorable John H. Lynch
Governor, State of New Hampshire
October 2009

Funding for this report and for the activities of the Child Fatality Review Committee comes from the U.S. Department of Health and Human Services Administration on Children, Youth and Families through the Children's Justice Act Grant (#G-08NHCJA1) which is administered by the New Hampshire Department of Justice.

TABLE OF CONTENTS

DEDICATION

As in previous years, the Committee would like to dedicate this, our Eleventh Report, to the children of New Hampshire and to those who work to improve their health and lives. For the last thirteen years that the Committee has been performing child death reviews, we have been sustained in the knowledge that what we do will improve the safety of New Hampshire's children and help to reduce the number of preventable deaths of children in our state.

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

October 2009

Dear Friends of New Hampshire's Children:

The New Hampshire Child Fatality Review Committee has begun its thirteenth full year of reviewing fatalities of New Hampshire's children. The work of the Committee is an effort to ensure the health and safety of the children of New Hampshire and to reduce the number of preventable child deaths.

The following is the Committee's Eleventh Annual Report, which reviews the work of the Committee for the calendar years of 2007 and 2008. Fatality data collected and analyzed by the Bureau of Health Statistics and Data Management is included for calendar year 2006 and is compared with that of the previous five years.

As in previous years, members of the New Hampshire Child Fatality Review Committee have made presentations in New Hampshire and nationally on the issues of child fatalities and on the work of the New Hampshire committee. We have been recognized nationally for our work and many states are interested in learning more about how we conduct our reviews and how we gather and respond to recommendations generated by these reviews. Additionally we host an annual meeting with the other New England teams (Maine, Vermont, Connecticut, Rhode Island and Massachusetts). These joint meetings give us an overview of the problems and solutions that the teams from other states encounter in trying to prevent child fatalities.

As Chair, I would like to acknowledge the hard work and dedication of the members of the Committee. I especially want to acknowledge Danielle (O'Gorman) Snook who, as our Administrative Assistant, has worked particularly hard this year to help the committee run smoothly and in preparing this annual report. Through the commitment of all our members, we have been able to build a collaborative network to foster teamwork and share the recommendations with the larger community.

I would also like to recognize those members who have completed their work on the team over the last two years. Without their assistance and professional input, our work would not be of the height that we have sustained over the years. These former members are Detective Sergeant Kathy Kimball, retired, New Hampshire State Police; Dr. Paul Spivack, Pediatrician; Ed DeForrest, Former President/CEO, Spaulding Youth Center Foundation and Joe Perry, LCSW, Former Administrator, Division of Behavioral Health.

In recognition of this commitment and dedication, it is with great pride that as Chair, I present this Eleventh Annual Report to the Honorable, Governor of the State of New Hampshire.

On behalf of the Committee,

Marc A. Clement, PhD
Chair, New Hampshire Child Fatality Review Committee

THE NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

MISSION STATEMENT

To reduce preventable child fatalities through systematic multidisciplinary review of child fatalities in New Hampshire; through interdisciplinary training and community-based prevention education; and through data-driven recommendations for legislation and public policy.

OBJECTIVES

1. To describe trends and patterns of child death in New Hampshire.

2. To identify and investigate the prevalence of risks and potential risk factors in the population of deceased children.

3. To evaluate the service and system responses to children who are considered high risk, and to offer recommendations for improvement in those responses.

4. To characterize high-risk groups in terms that are compatible with the development of public policy.

5. To improve the sources of data collection by developing protocols for autopsies, death investigations and complete recording of the cause of death on death certificates.

6. To enable parties to more effectively facilitate the prevention, investigation and prosecution of child fatalities.

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE MEMBERSHIP
January to December 2008

Chair: Marc Clement, PhD
Colby-Sawyer College

Thomas Andrew, MD, Chief Medical Examiner
Office of the Chief Medical Examiner

Maggie Bishop, Administrator
Division for Children, Youth & Families
Department of Health & Human Services

*Lorraine Bartlett
Division for Children, Youth & Families
Department of Health & Human Services

Paul Boisseau, Executive Secretary
Board of Pharmacy

*George Bowersox
Board of Pharmacy

William Boyle, MD
Dartmouth Hitchcock Medical Center

Deb Coe, MA
NH Coalition Against Domestic & Sexual Violence

Edward DeForrest, PhD, Former President/CEO
Spaulding Youth Center Foundation

J. William Degnan, State Fire Marshall
State Fire Marshall's Office

Diana Dorsey, MD, Pediatric Consultant
Department of Health & Human Services

*Jennie Duval, Deputy Chief Medical Examiner
Office of the Chief Medical Examiner

*Elizabeth Fenner-Lukaitis, LICSW
Acute Care Services Coordinator
Bureau of Behavioral Health

*Elaine Frank, Program Director
Injury Prevention Program
Dartmouth Hitchcock Medical Center

Janet Houston, Project Coordinator
NH EMS for Children
Dartmouth Medical School

Honorable David Huot
Laconia District Court
Detective Sergeant Kathy Kimball
NH State Police

Audrey Knight, MSN, RN, Child Health Nurse Consultant and
SIDS Program Coordinator
Division of Public Health Services

Honorable Willard Martin
Family Court Division

Sandra Matheson, Director
Office of Victim Witness Assistance
Attorney General's Office

*Susan Meagher
CASA of New Hampshire

John McDermott, Manager of Field Services
Division of Juvenile Justice Services
Department of Health and Human Services

Joe Perry, LCSW, Administrator
Bureau of Behavioral Health

Suzanne Prentiss, Bureau Chief
Division of Emergency Medical Services
Department of Safety

Deborah Pullin, BSN, ARNP, Coordinator
Child Advocacy & Protection Program
Dartmouth Hitchcock Medical Center

Katherine Rannie, RN, MS
School Health Services Coordinator
Department of Education

Rosemary Shannon, MSW, Administrator
Div. of Alcohol & Drug Abuse Prevention & Recovery
Department of Health & Human Services

Rhonda Siegel, MSEd
Injury Prevention, Adolescent Health, and Prenatal Program
Division of Public Health Services

Marcia Sink, Executive Director
CASA of New Hampshire

Danielle Snook, Task Force Program Specialist
Attorney General's Office

Paul Spivack, MD
Hitchcock Clinic

Robert Stafford, Assistant Director
Police Standards and Training Council

***= Alternate**

I. EXECUTIVE SUMMARY

This report reflects the work of the Committee during the 2007, 2008, and 2009 calendar years. The work of the Committee and the purpose of the recommendations that are produced during the reviews are to reduce preventable child fatalities in New Hampshire.

This report begins with the Committee's Mission Statement and Objectives, followed by a listing of the Committee members and their affiliations. There are a few short reports from representatives on the Committee on some of the initiatives they've been involved in related to the Committee. Following this is a review and analysis of the 2006 New Hampshire child fatality review data and a look at the last five years of data (2002 – 2006). The follow up to the 2007 and 2008 recommendations are presented along with the recommendations generated from the 2009 case reviews.

II. STATEMENT OF ACCOUNTABILITY

The New Hampshire Child Fatality Review Committee was established in 1991 by an Executive Order of then Governor Judd Gregg. Please refer to Appendix A for a summary of the history, background, and methodology of the Committee. In 1995, then Governor Merrill signed an Executive Order (Appendix B) reestablishing the Committee under the official auspices of the New Hampshire Department of Justice. To provide support to the review process, the Department heads of the New Hampshire Department of Justice, the New Hampshire Department of Health and Human Services, and the New Hampshire Department of Safety signed an Interagency Agreement (Appendix C) that defined the scope of information sharing and confidentiality within the Committee. Additionally, individual Committee members and invited participants are required to sign Confidentiality Agreements (Appendix D) in order to participate in the review process. The right to confidentiality for families who lost children is respected in the work of the Committee.

The New Hampshire Child Fatality Review Committee is funded by the New Hampshire Department of Justice through the Children's Justice Act (CJA) Grant, which is administered by the United States Department of Health and Human Services. In order to receive funding through the CJA Grant, which also supports the Attorney General's Task Force on Child Abuse and Neglect, the State is required by statute to establish a child fatality review panel "to evaluate the extent to which agencies are effectively discharging their child protection responsibilities." The New Hampshire Child Fatality Review Committee meets the criteria for this review panel (Appendix E).

The Committee membership (page vi) represents the medical, law enforcement, judicial, legal, victim services, public health, mental health, child protection, and education communities. The full Committee meets every other month to review the cases that have been selected by the Executive Committee, which meets in the alternate months. The case review protocol can be found in Appendix F. The purpose of the committee is to develop, as appropriate, recommendations to the Governor and relevant state agencies, with the intent of effecting change in state policy or practice, or to cause the development of new initiatives which could lead to the reduction of preventable deaths in children and youth. Committee recommendations for change

are developed with the goal of creating a meaningful impact for children and youth at risk due to common factors present across the category of children represented in reviewed cases.

The Committee also hosts an annual Northern New England Child Fatality Review Meeting. This day-long meeting convenes the Child Fatality Review teams from Maine, Vermont, Massachusetts, Connecticut, and Rhode Island to discuss child fatalities that involved more than one New England state, share ideas and experiences to improve the functioning of the teams, and explore how information can be more effectively shared by different state agencies.

This is the Eleventh Report of the Committee, and as in previous reports, the main components of the report are the data section and the section on recommendations generated during the case reviews. At the end of each year, the appropriate agencies are asked to respond to the recommendations generated by the Committee in the previous year. These responses are published along with the present year's recommendations. During 2007 and 2008, the Committee held 10 meetings, which involved the review of a total of seven cases. In 2009, there have been five Committee meetings that reviewed a total of five cases.

III. OTHER ACTIVITIES RELATED TO THE CHILD FATALITY REVIEW COMMITTEE

The following is a description of several of the activities carried out in 2007 and 2008 related to the work of the Committee.

Participation in National Child Death Review Efforts

Marc Clement, PhD, Chair of the Committee, presented at a national Child Death Review conference in Chicago, sponsored by the National Center for Child Death Review, on the differences between child death review in rural states (such as New Hampshire) and death reviews in urban states (Illinois, presented by a member of the Illinois team). He also collaborated with child death review professionals from 10 other states in writing, "A Program Manual for Child Death Review: Strategies to Better Understand Why Children Die & Taking Action to Prevent Child Deaths". This manual was prepared by the National Center for Child Death Review and child death leaders and advocates throughout the United States and supported by funds from The Maternal and Child Health Bureau, Health Resources and Services Administration, US Department of Health and Human Services. It serves as a guide to help states establish, manage, and evaluate effective child death review teams and team meetings, by sharing best practices.

Centers for Disease Control's 2007 Sudden Unexplained Infant Death Investigation National Training Academy

In May 2007, New Hampshire was invited to send a team to the New England regional presentation of the Centers for Disease Control's three-day Sudden Unexplained Infant Death Investigation National Training Academy. Each state was asked to send representatives from the following disciplines: Medical Examiner, Death Scene Investigators, Institutions of Higher Learning offering a Criminal Justice program, Child Protective Services, and Law Enforcement. Three members of the New Hampshire Child Fatality Review Committee attended: Dr. Thomas

Andrew, Chief Medical Examiner, also was a member of the Academy faculty, who represented the Medical Examiner's Office; Audrey Knight, RN, MSN, New Hampshire Division of Public Health's SIDS Program Coordinator, who attended on behalf of Child Protective Services; and Sergeant Kathy Kimball from the New Hampshire State Police, representing law enforcement. Additionally, Kim Fallon, Forensic Investigator from the Office of the Chief Medical Examiner, who works with the Assistant Deputy Medical Examiners attended on behalf of Death Scene Investigators; and Peter Stevenson, PhD, Associate Professor of Criminal Justice from Keene State College, attended on behalf of Institutions of Higher Learning.

Following the Academy, the team was responsible for conducting a series of follow up trainings to share the information on improving the death scene investigation and completion of the reporting forms. Information from the Academy was shared in over twenty trainings and workshops by members of the team to target audiences that included child welfare advocates, state troopers, Assistant Deputy Medical Examiners, physicians, nurses, hospital perinatal nurse managers and child care providers.

Mock Child Fatality Review Committee Workshop at the Annual Attorney General's Conference on Child Abuse and Neglect

Thomas Andrew, MD, New Hampshire Chief Medical Examiner, and Marc Clement, PhD, Committee Chair, presented at the Attorney General's Task Force on Child Abuse and Neglect 2007 and 2008 Annual Child Abuse and Neglect Conferences on the work of the Child Fatality Review Committee. Included in these presentations was a mock review that helped the participants understand how the New Hampshire team conducts its reviews.

Efforts to Improve the Child Fatality Review Committee's Recommendation Process

In follow up to a 2007 webcast on child fatality review activities sponsored by the National Center for Child Death Review and the federal Maternal and Child Health Bureau, New Hampshire has been working on improving its process for developing and tracking the recommendations generated during the Committee's review meetings. A new form, adapted from one used nationally, was developed for generating and tracking the recommendations. The form includes activities needed to carry out the recommendation, Committee members responsible for being the lead contact for following up on the recommendation, people identified as being needed to help carry out the activities, and the time frame for completing the activities and recommendation. The intent is also to check back on the progress of the recommendations at each subsequent committee meeting to assure that they are successfully achieved. The process of refining recommendations generated at the meetings so that they can be realistic, achievable, and measurable continues to be a work in progress.

IV. REVIEW AND ANALYSIS OF DATA

This report presents deaths among children birth through the age of eighteen who were residents of the state of New Hampshire. The data can be broken into two major classifications of death, natural causes and injuries. Both types of death are analyzed in this report. Death by natural causes is a strictly defined term utilized when the cause of death is due *exclusively* to disease with no contribution by any injury or other exogenous factor. It encompasses, but is not limited to, diseases of the heart, malignant neoplasms (i.e.; cancer), conditions originating in the

perinatal period (such as low birth weight and prematurity) and some sudden infant deaths. The other category of death is injury which refers to death from damage done to the structure or function of the body caused by an outside agent or force, which may be physical (as in a fall) or chemical (as in a burn or poisoning). Injury deaths are also classified as unintentional (such as in accidental drowning) or intentional (suicide or homicide).

The majority of deaths (83%) in children from birth through age eighteen were due to natural causes in year 2006 (Table 1). This was also the case for the five-year period ending in 2006 (74%). Infants under age one comprised the majority of deaths due to natural causes in both time periods, 58% and 54% respectively. Adolescents, on the other hand, account for the majority of injury related deaths, also in both time periods (11% and 16%).

Counts of events at 10 or less per year may be due to chance alone and do not produce reliable statistics. Use caution when interpreting small numbers and percentages derived from them.

New Hampshire Resident Natural and Injury Deaths
By Age groups, 0-18, 2006

Age Group	Natural	Injury	Total
<01	82 (58%)	5 (4%)	87 (62%)
01 to 04	11 (8%)	0 (0%)	11 (8%)
05 to 09	6 (4%)	2 (1%)	8 (6%)
10 to 14	7 (5%)	2 (1%)	9 (6%)
15 to 18	11 (8%)	15 (11%)	26 (18%)
Total	**117 (83%)**	**24 (17%)**	**141 (100%)**

New Hampshire Resident Natural and Injury Deaths
by Age Groups, 0-18, 2002-2006

Age Group	Natural	Injury	Total
<01	355 (54%)	16 (2%)	371 (56%)
01 to 04	35 (5%)	12 (2%)	47 (7%)
05 to 09	28 (4%)	14 (2%)	42 (6%)
10 to 14	27 (4%)	24 (4%)	51 (8%)
15 to 18	41 (6%)	109 (16%)	150 (23%)
Total	**486 (74%)**	**175 (26%)**	**661 (100%)**

Data Source: New Hampshire Department of Health and Human Services, Office of Health Statistics and Data Management (HSDM), Death Certificate Data provided by the Department of State, Division of Vital Records

As was stated previously, infants less than one year of age died primarily from natural causes. The majority of these deaths in both time periods were due to complications of prematurity, extreme immaturity, slow growth, and low birth weight. The percentage of infants who died from these causes, 50% and 54%, was between three and four times that of the next two causes of death, congenital malformations, deformations, and chromosomal abnormalities

(12% and 17%) and "sudden infant death syndrome" (18% and 12%). There was no statistical significance within any cause of death between the two time periods. There also has been no significant change between this data and those in the last bi-annual report, encompassing the years 2002 through 2004.

Leading Causes of Natural Child Death, Ages <1, New Hampshire, 2002-2006

Natural Causes of Death	2006	2002-2006
Prematurity, Extreme Imaturity, Slow Growth, Low Birth Weight	50%	54%
Congenital malformations, deformations and chromosomal abnormalities	12%	17%
Sudden infant death syndrome	18%	12%
Respiratory or Lung Issues, Aphyxia	6%	6%
Other Causes	5%	3%
Heart or Cardiac Issues	1%	1%
Cerebrovascular diseases	2%	1%
Influenza or Pneumonia	1%	1%
Newborn affected by complications of placenta, cord and membranes	2%	1%
Sepsis	0%	1%
Liver or Hepatic Issues	0%	1%
Benign, Uncertian, or Malignant Neoplasms	1%	1%
Total	**82**	**355**

Data Source: Web-based Injury Statistics Query and Reporting System (WISQARS). National Center for Health Statistics (NCHS), National Vital Statistics System. Produced By: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, http://www.cdc.gov/injury/wisqars/index.html.

Suffocation was the leading cause of unintentional injury death for children under the age of one, both in 2006 and in the aggregated five-year period ending in 2006. Suffocation deaths in this age group included, but were not limited to, infants who died in unsafe sleep situations. There was no statistical difference between the two time frames. This mirrors national statistics and is consistent with data from 2002 through 2004. There was also no significant difference in the deaths between male and female infants.

NH Resident Deaths, by Age Groups, Injury Intent, and Cause of Death, 2002-2006

	Year(s)>>>	2006						2002-2006					
Injury Intent	Cause of Death	<01	00-04	05 to 09	10 to 14	15 to 18	Total	<01	00-04	05 to 09	10 to 14	15 to 18	Total
Unintentional	Motor vehicle traffic			2		8	10 (42%)		3	6	7	56	72 (41%)
	Other land transport										2	5	7 (4%)
	Fire or hot object/ substance								1	2	3		6 (3%)
	Other transport									2	1	1	4 (2%)
	Other					1	1 (4%)					2	2 (1%)
	Drowning	1					1 (4%)	2	3	3	1	5	14 (8%)
	Suffocation	4			1		5 (21%)	12	1		1		14 (8%)
	Poisoning					5	5 (21%)				1	12	13 (7%)
	Firearm											1	1 (1%)
	Natural/environmental							1					1 (1%)
	Pedal cyclist - other										1		1 (1%)
	Pedestrian - other								1				1 (1%)
	Struck by or against											1	1 (1%)
Unintentional	**Total**	**5**	**0**	**2**	**1**	**14**	**22 (92%)**	**15**	**9**	**13**	**17**	**83**	**137 (78%)**

Data Source: New Hampshire Department of Health and Human Services, Office of Health Statistics and Data Management (HSDM), Death Certificate Data provided by the Department of State, Division of Vital Records.

The majority of deaths due to natural causes in 1 to18 year olds were due to two major categories: “Other”, which includes a wide variety of infrequent causes of death, and “malignant neoplasms”.

Leading Causes of Natural Child Death, Ages 1 to 18 Years, New Hampshire, 2002-2006

New Hampshire Residents, Age 1 to 18 Years

Cause of Death	2006	2002-2006
Malignant Neoplasms	9 (38%)	39 (43%)
Heart Disease	7 (29%)	13 (14%)
Congenital Anomalies	2 (8%)	13 (14%)
Benign Neoplasms	3 (13%)	4 (4%)
Influenza & Pneumonia	1 (4%)	4 (4%)
Cerebrovascular Disease	1 (4%)	3 (3%)
Perinatal Period	1 (4%)	3 (3%)
Chronic Lower Respiratory		3 (3%)
Diabetes Mellitus		2 (2%)
Pneumonitis		2 (2%)
Meningitis		1 (1%)
Nephritis		1 (1%)
Peptic Ulcer		1 (1%)
Septicemia		1 (1%)
WISQARS Total	**24 (100%)**	**90 (100%)**
HSDM Total	**45**	**131**

Data Source: Web-based Injury Statistics Query and Reporting System (WISQARS). National Center for Health Statistics (NCHS), National Vital Statistics System. Produced By: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, http://www.cdc.gov/injury/wisqars/index.html.

Motor vehicle crash injuries were the leading cause of death, exceeding even those due to natural causes for adolescents 15 through 18 in both time periods. More adolescents died due to motor vehicle crashes than all other unintentional injuries combined. This is consistent with national data. There is no significant difference between the two time periods.

Males were three times more likely than females in this age category to die because of any kind of unintentional injury.

NH Resident Deaths, by Gender, Age Groups, and Injury Intent, 2002-2006

	Gender>>>>	Female						Male						Total
Year(s)	Age Group>>>> Injury Intent	<01	01 to 04	05 to 09	10 to 14	15 to 18	Total Female	<01	01 to 04	05 to 09	10 to 14	15 to 18	Total Male	Total Both Genders
2006	Homicide	0	0	0	0	1	**1 (13%)**	0	0	0	0	0	**0 (0%)**	**1 (4%)**
2002-2006	Homicide	0	1	1	1	1	**4 (8%)**	1	1	0	0	0	**2 (2%)**	**6 (3%)**
2006	Suicide	0	0	0	1	0	**1 (13%)**	0	0	0	0	0	**0 (0%)**	**1 (4%)**
2002-2006	Suicide	0	0	0	1	7	**8 (15%)**	0	0	0	4	15	**19 (16%)**	**27 (15%)**
2006	Undetermined	0	0	0	0	0	**0 (0%)**	0	0	0	0	0	**0 (0%)**	**0 (0%)**
2002-2006	Undetermined	0	1	0	1	2	**4 (8%)**	0	0	0	0	1	**1 (1%)**	**5 (3%)**
2006	Unintentional Injury	2	0	0	0	4	**6 (75%)**	3	0	2	1	10	**16 (100%)**	**22 (92%)**
2002-2006	Unintentional Injury	8	1	3	4	21	**37 (70%)**	7	8	10	13	62	**100 (82%)**	**137 (78%)**
2006	**Total (HSDM)**	**2**	**0**	**0**	**1**	**5**	**8 (100%)**	**3**	**0**	**2**	**1**	**10**	**16 (100%)**	**24 (100%)**
2002-2006	**Total (HSDM)**	**8**	**3**	**4**	**7**	**31**	**53 (100%)**	**8**	**9**	**10**	**17**	**78**	**122 (100%)**	**175 (100%)**
2006	**Total (WISQARS)**													**25**
2002-2006	**Total (WISQARS)**	Please note: Data from HSDM website may vary slightly WISQARS data.												**171**

Data Source: New Hampshire Department of Health and Human Services, Office of Health Statistics and Data Management (HSDM), Death Certificate Data provided by the Department of State, Division of Vital Records.

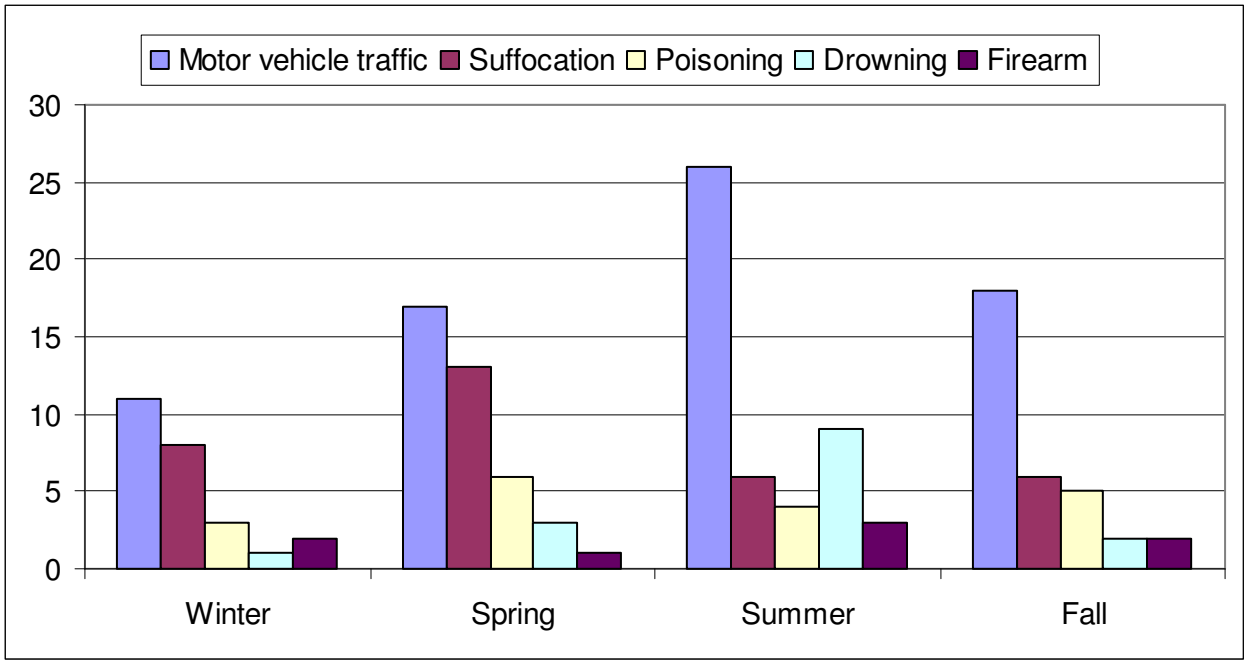
Suicidal violence is also a leading cause of death for those ages 15-18 years. The year 2006 was unusual in that unlike other years, there were no deaths with manner certified as suicide in adolescents 15 through 18. Suffocation was the leading mechanism in suicide deaths for both time periods. ("Suffocation," an unfortunate term chosen for uniformity of national statistics, would be more accurately characterized as asphyxia and most commonly involves hanging.) Again this is consistent with previous years. Males were more likely to die by suicide than were females. Once again, this has been consistent through the years and is similar with national statistics.

Looking at seasonal variations of injury deaths by mechanism, there appears to be an increased amount of child deaths due to fire or hot object/substance (i.e. burns) in the winter. This agrees with national data and is due primarily to fires ignited by heating mechanisms. Another seasonal difference can be seen in the increase in drowning in the spring and summer. Most drownings of children in the state occur in natural bodies of water, consistent with the seasonal differences. Motor vehicle crashes were higher in the summer, probably due to the larger number of vehicle miles traveled and also similar to national data.

Mechanism of Injury Deaths by Season, New Hampshire Residents, Age 0 to 18 years, 2002-2006

Cause of Injury Death	Winter	Spring	Summer	Fall	Total
Motor vehicle traffic	11	17	26	18	72
Suffocation	8	13	6	6	33
Poisoning	3	6	4	5	18
Drowning	1	3	9	2	15
Firearm	2	1	3	2	8
Other land transport	3	2	2	0	7
Fire or hot object/substance	5	0	1	0	6
Other, specified or unspecified	3	2	1	0	6
Other transport	0	2	2	0	4
Cut/pierce	0	0	0	2	2
Natural/environmental	0	1	0	0	1
Pedal cyclist - other	0	1	0	0	1
Pedestrian - other	0	1	0	0	1
Struck by or against	1	0	0	0	1
Total	**37**	**49**	**54**	**35**	**175**

Top 5 Mechanisms of Injury Deaths by Season, New Hampshire Residents, Age 0 to 18 years, 2002-2006



Data Source: New Hampshire Department of Health and Human Services, Office of Health Statistics and Data Management (HSDM), Death Certificate Data provided by the Department of State, Division of Vital Records.

VI. RESPONSES TO 2007 AND 2008 RECOMMENDATIONS

A 15-year old male drowning fatality.

- ***Department of Environmental Services should change their rules to require that facilities with pools have a standard Emergency Action Plan, ongoing in-services with lifeguards, rules and regulations, and should monitor facilities to ensure compliance. Facilities with pools should have the option of doing a voluntary certification program which focuses on lifeguard training.***

Representatives from Safe Kids New Hampshire spoke with colleagues about putting together a study group to explore voluntary certification for pool facilities focusing on lifeguard training. Safe Kids New Hampshire is a member of Safe Kids USA, and Safe Kids Worldwide, a global network of organizations whose mission is to prevent accidental childhood injury, a leading killer of children 14 and under. This was determined not to be feasible.

- ***Educational institutions, that have pools or sanctioned swim programs should include age appropriate education about swimming and breath holding as part of their curriculum.***

The Department of Education does not oversee pools. The Department of Education does periodically provide information about water safety to schools via the school nurse list serve in a variety of formats. Information about breath holding was circulated on two occasions via the school nurse list serve. No public schools in New Hampshire have pools, but water safety is recommended as part of a comprehensive K-12 health education program.

- ***The public should be educated on the dangers of breath holding while swimming.***

The American Academy of Pediatrics (AAP) was contacted regarding educational materials relevant to under water breath holding. Currently the AAP does not have any educational materials on this issue and is not actively in the process of developing any at this time.

An AAP pediatrician on the Committee on Injury, Violence and Lead Poisoning Prevention submitted to the AAP a request to develop an educational brochure/handout regarding the dangers of breath holding under water. This pediatrician will continue to work with his AAP committee on this issue.

An inquiry was made to New Hampshire Safe Kids to develop a handout regarding the dangers of breath holding under water. New Hampshire Safe Kids stated that at this time they would not be developing a handout on breath holding under water.

The Concord Office of the American Red Cross was contacted regarding the issue of including information on breath holding in their training. Their representative responded that information on breath holding under water is covered in Basic Swimming lessons. However, the focus is more on what swimmers should do ("blow bubbles out") versus what swimmers shouldn't do. Hypoxic training is an advanced skill for those in competitive swimming classes of older teens, for ages fifteen and over.

A 12-day-old girl, one of twins, died while bed sharing with her mother and twin. Her death was ruled Undetermined, Category II Sudden Infant Death Syndrome. This was the second death of a child in this family within a year.

- ***Improve the knowledge of judges who sit on child abuse and neglect cases, about the standard of proof in child abuse cases and about the pathology of child abuse and neglect, especially regarding injuries to infants and young children.***

Meetings with the courts and others relative to this recommendation resulted in some clarification and changes. It was determined that there was a need for training for judges on this issue, especially as family court rolls out state wide, to assure an understanding of best practices in child abuse cases. The specific medical aspects of child abuse, however was identified as a training need for DCYF attorney staff. Therefore, the recommendations were brought to and merged with already existing efforts underway with the Court Improvement Project as outlined below.

The Court Improvement Project (CIP) is a federally funded project that supports states in improving court practices in child abuse and neglect cases. This project creates the ability and structure to provide on-going training across the state as needed to assure that future changes in staff within any system can receive training on best child welfare practices.

For several years, DCYF has partnered with the courts, through their CIP coordinator, to improve court practices in child abuse/neglect cases. The Division leadership and New Hampshire's CIP Coordinator have maintained meaningful, on-going collaborations that have clearly resulted in the court and the child welfare agency being able to successfully identify and work toward shared goals and activities.

There are many joint statewide learning opportunities and program initiatives that have begun over the past two years and are ongoing. This has allowed each system to be able to successfully identify and work toward shared goals and activities. These joint statewide learning opportunities, program initiatives, and trainings have resulted in improved practices.

Supporting and cosponsoring comprehensive skill-based training for judges, attorneys, DCYF and CASA staff have assured sustainable practice changes within all systems. The leadership within each system has engaged in and supported multi-disciplinary work to plan and carry out cross system training.

The CIP Training Grant has supported many opportunities for judicial training in 2008. The CIP sent five judges and masters to the National Council for Juvenile and Family Court Judges annual Child Abuse and Neglect Institute in Reno, Nevada. It was also possible to send three judges to the National Council's conference, "Evidence in Family Law." The CIP also supported a judge in taking an on-line course called "Rural Courts" as that particular judge presides in one of the most rural areas of the state The Family Division also hosted two education days for the Judges and Marital Masters. These consistent training opportunities allowed the CIP to present information about the changes in the law and practice implications for permanency planning for juvenile cases and also about the statutory changes regarding the courts, schools, and children with disabilities. In September, the CIP also supported eight

judges, a District Court Administrator and six court staff to attend the annual Attorney General's Conference on Child Abuse and Neglect.

- ***Encourage radiologists to have continuing education on radiographic evidence of child abuse.***

  No successful follow-up on this recommendation.

- ***Encourage hospitals, in the process of reappointing their radiologist medical staff, to require evidence of current competencies of recognizing radiographic evidence of child abuse.***

  No successful follow-up on this recommendation.

- ***Explore adding to the licensure requirements of health professionals that continuing education be required in the area of recognizing and reporting signs of child abuse and neglect***

New Hampshire Medical Society and New Hampshire Board of Medicine were contacted relative to adding Continuing Medical Education (CME's) on child abuse and neglect to the licensing requirements of health professionals in New Hampshire. The Medical Society Board discussed the request from the CFRC regarding mandatory CME for child abuse and neglect recognition. All members were supportive of the issue, however they did not endorse it. The main reasons are (1) Too many potential topics may then be requested to be mandated by others with their own interests (2) Healthcare professionals want to be able to choose what is beneficial to their patients (3) Hospitals are trying to set what CME requirements are needed to obtain medical staff privileges.

The New Hampshire Board of Nursing was contacted regarding adding mandatory Continuing Education Units (CEU's) on child abuse and neglect to the licensing requirements of health professionals in New Hampshire. This would require a rule change, which is not easily achievable at this time.

The New Hampshire Board of Mental health was contacted regarding this recommendation. There was some interest and enthusiasm expressed about this endeavor, however, it would require a Rule change. A Rule change entails numerous public feedback sessions, a fair amount of written and oral presentations and no guarantee that it would be passed.

The costs and benefits of exerting the time and effort necessary for this to occur were shared during a follow up CFRC meeting. The CFRC felt this was not something that could be pursued at this time.

In June 2009, the American Academy of Pediatrics published in print and online, two policy statements. One was on "Abusive Head Trauma in Children" and the other was on "Diagnostic Imaging of Child Abuse" which physicians were made aware of. These can be found at the official website of the American Academy of Pediatrics, www.AAP.org.

- ***Understand current practices on the way infant care health and safety information is disseminated to new parents.***
- ***Assure that all new parents are educated about health and safety issues in raising a child to prevent child abuse and neglect.***

Information about the health and safety issues in raising a child, to prevent child abuse and neglect, is provided to expectant and new parents by a wide variety of prenatal and pediatric health care providers, hospitals, parenting resources, and state and federally funded programs, clinics, and initiatives. The American Academy of Pediatrics' "Bright Futures – Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition" recommends specific age-appropriate guidance that should be provided at each child health visit. There is currently no way to assure that the information provided to all new parents is consistent. Several strategies were discussed to assess the information being provided by the broad range of health care professionals, but the strategies were unable to be actualized. The New Hampshire birthing hospitals' Perinatal Nurse Managers were informally surveyed regarding the child abuse material given to new mothers prior to discharge. The few hospitals that responded indicated that they are using a handout on preventing Shaken Baby Syndrome that is no longer in print and contains outdated resource information. The New Hampshire Children's Trust Fund is interested in convening a workgroup to develop a brochure for parents on this topic.

- ***Educate teenagers regarding keeping children in childcare situations safe, and how to recognize and report child abuse.***

Information about child abuse is routinely shared with schools. The Department of Education offers guidance to teachers via a protocol available on the Department of Education's website: http://www.ed.state.nh.us/education/doe/ChildAbuseandReportingProtocol.htm. School nurses work with pregnant and parenting teens on a case-by-case basis and offer extensive support as needed that would include anticipatory guidance about childcare arrangements.

- ***Support and advocate for the continuation of home visiting programs such as "Home Visiting New Hampshire".***

The Commissioner of Heath and Human Services, the Legislature and the Governor will receive copies of the CFRC Annual Report, which highlights this recommendation. Funding for the continuation of the Department of Health and Human Services' Home Visiting New Hampshire program has been assured, to date, for Fiscal Year 2010.

- ***Educate CPSWs on assessing home safety during in home visits.***

Child Protection Service Workers (CPSW) are educated during the course of participation in CORE Training about what to look for in assessing safety of children during home visits. CPSW's are trained in assessing basic care, hygiene, shelter and exposure to elements to determine the adequacy of the care and supervision the child is receiving. This includes assessing potential safety and risk factors associated with exposure to unsafe and unsanitary living, access and exposure to animal waste, malnutrition, emotional and psychological maltreatment, domestic violence and substance abuse. CPSW's do not receive specific training regarding safe sleeping with infants during routine visits. However, the Division of Children, Youth, and Families and the Maternal and Child Health Section of the Department of Health and Human Services are in

discussion about the potential use of already existing safety materials that could be used for future trainings with DCYF staff.

Currently, the curriculum for the Home Visiting New Hampshire Program, within the Maternal and Child Health Section of the Department of Health and Human, has limited core safety messages embedded in its curriculum. There is an opportunity to work with the Healthy Homes Initiative, also within the Maternal and Child Health Section, to integrate safety messages across programs in order to reach more families.

- ***Improve current process for selecting cases for review at Child Fatality Review Committee Meetings.***

The Child Fatality Review Committee's Executive Committee, which alternates monthly meetings with the full Committee, now reviews preliminary information on any infant/child deaths autopsied by the Office of the Chief Medical Examiner that have occurred since the Executive Committee last met. Cases not selected for review, for whatever reason, but of possible interest for a future review, are now recorded on a tracking form. The tracking form is reviewed at each Executive Committee meeting should there be any change in the case's status, allowing it to be reviewed. Use of the tracking form was developed to prevent cases valuable for full committee review, from slipping through the cracks.

- ***Encourage assessment of co-occurring issues of parental substance abuse, domestic violence and mental health issues when providing medical care to children.***

The national recommendations for screening for substance abuse, depression and Domestic Violence (DV) are included in the American Academy of Pediatrics' "Bright Futures – Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition". This book is the official handbook for primary care providers of children and is published by the American Academy of Pediatrics with funding from the US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau.

In March 2007 the American Academy of Pediatrics (AAP) published an article "Factors Associated with Identification and Management of Maternal Depression by Pediatricians" in their official journal, Pediatrics. As well, the August 2007 issue contained an article titled, "Implementing Maternal Depression Screenings". This journal is widely read by pediatricians. The AAP has a Policy Statement from its Committee on Child Abuse and Neglect entitled, "The Role of The Pediatrician in Recognizing and Intervening on Behalf of Abused Women". This is available in print and online.

In April 2009 Children's Hospital at Dartmouth and The Family Place at Dartmouth-Hitchcock Medical Center, held their annual "Shield our Children" conference, which included the interface between child maltreatment and substance abuse. Dartmouth Hitchcock Medical Center has done medical conferences on this topic on a frequent basis over the last few years for resident doctors, and anticipates that this will continue. There have been other conferences at Dartmouth regarding domestic violence. An educational pocket card on domestic violence screening and resources was created for resident doctors. The Domestic Violence Protocol is available on the DHMC intra-net. Dartmouth Hitchcock Medical Center has sponsored at least one conference with Vermont on the effects of domestic violence on children.

The New Hampshire Pediatric Society has incorporated in one of their conferences a session on screening for depression and helping children of depressed parents build resilience. In the fall of 2009, the New Hampshire Pediatric Society's annual continuing education offering will address the topic of child abuse and neglect.

A 4 month old infant, born premature, was found in his crib, on his stomach.

Cause of death was Hyperthermia.

- ***Obtain an accurate core body temperature as soon as possible.***

The Emergency Medical Services New Hampshire Statewide Patient Care Protocols published in 2009 calls for obtaining a temperature, preferably rectal, under both Protocol 1.0 Routine Patient Care and more specifically Protocol 2.5 Hyperthermia. This is for both adults and children. Obtaining a temperature, after securing any other potential threats to life (airway, breathing and circulation), is key to setting the appropriate course for an effective treatment plan, from the field to the Emergency Department.

- ***Encourage pediatricians to attend the Primary Care Physician healthcare initiative training on domestic violence, safely screen for high-risk psycho-social factors, know what social support services are available and make appropriate referrals as often as needed.***

Heather Farr, the State Sexual Assault Nurse Examiner (SANE) Director, has recently finished revising the Domestic Violence Protocol for Health Care Professionals. This protocol emphasizes that universal screening for domestic violence should be done at every medical appointment and emergency room visit. Since January 2009, Heather has provided training for hospital Grand Rounds, hospitals, primary care providers and the New Hampshire Nurses Association. She has also reached out to the New Hampshire Pediatric Society and has not heard back from them as of this writing.

- ***Encourage sequential K – 12 Health Education that follows the current New Hampshire Health Education Curriculum Guidelines thus promoting health knowledge and skills so that students can learn to make healthy choices and avoid risky behavior.***

The New Hampshire State Department of Education (DOE) has consistently encouraged sequential K-12 Health Education over the years with documentation of student progress, success and achievement of competencies, demonstrating the capacity to obtain, interpret and understand basic health information in ways that enhance personal health. The DOE, by law, is required to ensure that health education is thoroughly taught as part of the basic curriculum (RSA 189.10). The DOE offers and promotes the New Hampshire Health Education Curriculum Guidelines that can be found on this website: http://www.ed.state.nh.us/education/doe/organization/instruction/HealthHIVAIDS/nhhealtheducationcurriculumguidelines.htm Versions that target elementary, middle and high school are online for ease of use. This year, a school approval visit team of education employees assessed minimum standards and reviewed health curriculum in five school districts. Recommendations were issued to these schools.

A 6-week-old male died while bed sharing with his mother. The baby was found on his back, with a quilt and 5- 6 pillows in the adult bed. Hospital nursery staff and community supports had been concerned about the mother's ability to care for the baby. Cause of death was "Undetermined".

- ***Increase the number of prenatal providers that refer woman early in their pregnancy to local home visiting programs that can offer psychosocial support and parenting education services.***

Due to fiscal constraints, continuation of the state-funded Home Visiting New Hampshire Programs has been uncertain up until the signing of the state budget on June 30, 2009, by the Governor. As a result, the Home Visiting Programs were not encouraged to do outreach to expand their caseloads. Approval has been issued for funding the programs for SFY2010 only. Outreach to low income women who may be at higher risk due to compounding psychosocial factors, about the availability of the Home Visiting Programs, will be prioritized. Home Visiting Program Coordinators will be encouraged at their fall 2009 meeting to do this outreach. A brochure for obstetrical providers outlining the services and benefits of the Home Visiting New Hampshire Program is planned.

- ***Increase awareness of the importance of reporting suspected abuse/neglect, and overcoming barriers for not reporting.***

DCYF has taken a proactive approach to increasing awareness of the importance of reporting suspected abuse and neglect through outreach to community stakeholders and providers. At the state level, DCYF has an established Speaker's Bureau comprised of Child Protection Staff and Supervisors who will provide training as requested.

In 2008, DCYF provided training about reporting laws as part of the regional training on the 2008 Revised Protocols on Child Abuse and Neglect. This training was provided to approximately 400 professionals, including DCYF staff, Law Enforcement, Medical Personnel and others in seven regions between December 2008 and May 2009. Training is also provided by DCYF on an ongoing basis to community agencies, school district, law enforcement, Head Start Programs, day cares and residential facilities by DCYF staff at the local level and by the DCYF Central Intake Supervisor. The Central Intake Supervisor routinely offers to provide training to school personnel who contact Central Intake regarding the availability of training. In addition, the DCYF Child Protection Administrator provided training on reporting Abuse and Neglect to case managers and counselors from the Berlin and Laconia correctional facilities. In September 2009 DCYF will be training Residential Counselors at the Sununu Center.

During the upcoming year DCYF will be seeking further opportunities to educate the community about reporting laws, including outreach to hospitals and other professional organizations to advise of the availability of training and materials to increase awareness of the importance of reporting.

V. 2009 RECOMMENDATIONS

In the calendar year 2009, the Committee reports the following recommendations, from the Committee to date, which are intended to help reduce child fatalities through enhanced policy development and service delivery within and among the agencies that serve children and families.

- Increase public awareness of preventing Shaken Baby Syndrome and of the dangers of touching a child in anger through the mechanism of PSA's.
- Address failure to report suspicions of serious abuse and neglect by emergency providers.
- Improve documentation of suspected child abuse in the medical record – detailing the circumstances as explained.
- Improve the reporting of suspected child abuse/neglect by hospital emergency room staff.
- Endorse the greater collaboration between schools and the community mental health centers regarding early identification and referral of youth with emerging mental health issues.
- Endorse the continuation and expansion of funding and support of school based early identification and referral programs.
- Endorse increasing the funding to community mental health centers to increase the number of providers available to meet community needs.
- Encourage school nurses to connect with the local Community Mental Health Centers, and vice versa
- Endorse the work of the Suicide Prevention Council and the suicide Survivor packet.
- Promote the use of Critical Incident Stress Management and other post-vention efforts for first responders.

VII. CONCLUSION

It is the hope of the Committee that this report has highlighted the work of the New Hampshire Child Fatality Review Committee. We hope also that it will help to strengthen your resolve to work, as an individual or a member of a public or private agency, to reduce the incidence of preventable deaths of children in New Hampshire.

APPENDIX A. HISTORY, BACKGROUND AND METHODOLOGY

(As printed in the Fourth Annual Report)

In 1999, there were 143 deaths in the state of New Hampshire involving children up to the age of 18. This compares with 134 deaths in 1997 and 119 deaths in 1998. The data presented here and in the Committee's first three annual reports shows that the great majority of the child fatalities in New Hampshire are from natural causes and that relatively few children die of preventable injury. These are the children that are of concern to the Committee and it is the task of the Committee to determine whether certain actions could have been taken to prevent these tragedies.

The Committee's First Annual Report provided an overview of the history of child fatality review committees, from their founding in Los Angeles County in 1978. In 1991, then Governor Judd Gregg signed an Executive Order creating a multidisciplinary Child Fatality Review Committee in New Hampshire. To assist with the initial implementation of the Committee, the University of New Hampshire Family Research Laboratory was commissioned to conduct a base-line study of child deaths in New Hampshire and to provide recommendations for how the Committee should operate.

After reviewing the study findings and initiatives from other states, the Committee was restructured to accommodate the demands of an on-going review process. In 1995, in an effort to support the restructuring, then Governor Stephen Merrill signed a new Executive Order (Appendix A) re-establishing the Committee under the official auspices of the New Hampshire Department of Justice. The Executive Order authorizes the Committee to have access to all existing records regarding child deaths, including social service reports, court documents, police records, autopsy reports, mental health records, hospital or medical data and other information that may be relevant to the review of a particular child death. To provide further support to the review process, the department heads of the New Hampshire Department of Justice, the New Hampshire Department of Health and Human Services and the New Hampshire Department of Safety signed an Interagency Agreement (Appendix B) that defined the scope of information sharing and confidentiality within the Committee. Additionally, individual Committee members and invited participants are required to sign Confidentiality Agreements (Appendix C) in order to participate in the review process.

The New Hampshire Child Fatality Review Committee is funded by the New Hampshire Department of Justice through the Children's Justice Act (CJA) Grant, which is administered by the US Department of Health and Human Services. In order to receive funding through the CJA Grant, which also supports the Attorney General's Task Force on Child Abuse and Neglect, the State is required by statute to establish a child fatality review panel "to evaluate the extent to which agencies are effectively discharging their child protection responsibilities." The New Hampshire Child Fatality Review Committee meets the criteria for this review panel (Appendix D).

The Committee membership is comprised of representation from the medical, law enforcement, judicial, legal, victim services, public health, mental health, child protection and education communities. Currently, the Committee has a dual structure consisting of the full

Committee, which convenes bimonthly to conduct in-depth reviews of specific cases involving child fatalities, and the Executive Committee, which convenes on alternate months to select cases for review, collect data and provide organizational support to the Committee.

The Committee began reviewing cases of child fatalities in January of 1996. In addition to the regular meeting schedule, the Committee hosted a joint meeting in November of 1998 with Child Fatality Review Teams from Vermont, Maine and Massachusetts. This meeting provided a forum for participants to come together and learn about some of the issues that other teams encounter in their efforts to review child deaths. It also offered an opportunity for members to establish contacts with their counterparts in other states. Participants from Maine, New Hampshire and Vermont continue to meet annually to further explore areas of common interest and to examine in more detail how each state conducts case reviews.

In New Hampshire, cases to be reviewed by the full Committee may be selected by individual members or agencies. The Committee does not review cases that have criminal and/or civil matters pending. After a case is found to be appropriate for review, the Executive Committee begins to gather information and invite participants from outside the committee who have had direct involvement with the child or family prior to the child's death.

Each child death is reviewed using the following review process (see Case Review Protocol, page three):

- The Medical Examiner's Office presents a clinical summary of the death. Other participants who had prior involvement with the child and family then present relevant medical, social and legal information.

- The Committee discusses service delivery prior to the death, and the investigation process post death.

- The Committee identifies risk factors related to the death and makes recommendations aimed at improving systematic responses in an effort to prevent similar deaths in the future.

- The Committee provides recommendations to participating agencies and encourages them to take actions consistent with their own mandates.

APPENDIX B: EXECUTIVE ORDER

STATE OF NEW HAMPSHIRE

CONCORD, NEW HAMPSHIRE 03301

Executive Order Number 95-1

an order establishing a New Hampshire
child fatality review committee

WHEREAS, as Governor I have expressed special interest in improving services to children who are victims of abuse and neglect; and

WHEREAS, the U.S. Advisory Board on Child Abuse and Neglect has recommended that efforts be made to address the issue of child fatalities; and

WHEREAS, the formation of a standing committee composed of representatives of state agencies and relevant professional fields of practice will establish a useful repository of knowledge regarding child deaths; and

WHEREAS, in order to assure that New Hampshire can provide a continuing response to child fatality cases, the New Hampshire Child Fatality Review Committee must receive access to all existing records on each questionable or unexplained child death. This would include social service reports, court documents, police records, autopsy reports, mental health records, hospital or medical related data and any other information that may have a bearing on the involved child and family; and

WHEREAS, the comprehensive review of such child fatality cases by a New Hampshire Child Fatality Review Committee will result in the identification of preventable deaths and recommendations for intervention strategies; and

WHEREAS, the New Hampshire Child Fatality Review Committee represents an additional aspect of our effort to provide comprehensive services for children throughout the State of New Hampshire;

NOW, THEREFORE, I, Stephen Merrill, Governor of the State of New Hampshire, do hereby establish a multi-disciplinary child fatality review committee. The objectives of this committee shall be:

1. To enable all interested parties to more effectively facilitate the prevention, investigation and prosecution of child fatalities.

2. To identify and investigate the prevalence of a number of risks and potential risk factors in the population of deceased children.

3. To evaluate the service system responses to children and families who are considered to be high risk, and to offer recommendations for any improvements in those responses.

4. To identify high risk groups for further consideration by executive, legislative or judicial branch programs.

5. To improve the sources of data collection by developing protocols for autopsies, death investigations and complete recording of cause of death on the death certificates.

6. To describe trends and patterns of child deaths in New Hampshire.

Given under my hand and seal at the Executive Chambers in Concord, this 29th day of September in the year of our Lord, one thousand nine hundred and ninety-five.

Governor of New Hampshire

APPENDIX C: INTERAGENCY AGREEMENT

ATTORNEY GENERAL
DEPARTMENT OF JUSTICE
33 CAPITOL STREET
CONCORD, NEW HAMPSHIRE 03301-6397

KELLY A. AYOTTE
ATTORNEY GENERAL

MICHAEL A. DELANEY
DEPUTY ATTORNEY GENERAL

INTERAGENCY AGREEMENT

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

This cooperative agreement is made between the New Hampshire Department of Justice, the New Hampshire Department of Health and Human Services and the New Hampshire Department of Safety.

WHEREAS, the parties hereto are vested with the authority to promote and protect the public health and to provide services which improve the well-being of children and families; and

WHEREAS, under RSA 125:9 II, the Department of Health and Human Services – Division for Public Health has the statutory authority to: "Make investigations and inquiries concerning the causes of epidemics and other diseases; the source of morbidity and mortality; and the effects of localities, employment, conditions, circumstances, and the environment on the public health;" and

WHEREAS, under RSA 169-C, the Department of Health and Human Services – Division for Children, Youth and Families has the responsibility to protect the well-being of children and their families; and

WHEREAS, the objectives of the New Hampshire Child Fatality Review Committee are agreed to be:

1) To describe trends and patterns of child deaths in New Hampshire.
2) To identify and investigate the prevalence of a number of risks and potential risk factors in the populations of deceased children.
3) To evaluate the service and system responses to children and families who are considered to be high risk, and to offer recommendations for improvement in those responses.
4) To characterize high risk groups in terms that are compatible with the development of public policy.
5) To improve the sources of data collection by developing protocols for autopsies, death investigations and complete recording of cause of death on the death certificates.

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6. To enable the parties to more effectively facilitate the prevention, investigation and prosecution of child fatalities.

WHEREAS, all parties agree that the membership of the New Hampshire Child Fatality Review Committee needs to be comprised of the following disciplines: law enforcement, judiciary, medical, mental health, public health, child protection services, with specific membership from designated agencies to include, but not to be limited to: the Office of the Chief Medical Examiner, the New Hampshire Pediatric Society and the New Hampshire SIDS Program; and

WHEREAS, the parties agree that meetings of the New Hampshire Child Fatality Review Committee will be held no fewer than six (6) times per year to conduct reviews of child fatalities:

NOW, THEREFORE, it is hereby agreed that the New Hampshire Child Fatality Review Committee convenes under the official auspices of the New Hampshire Department of Justice. All members of the New Hampshire Child Fatality Review Committee will sign a confidentiality statement that prohibits any unauthorized dissemination of information beyond the purpose of the review process. The New Hampshire Child Fatality Review Committee shall not create new files with specific case-identifying information. Non-identified, aggregate data will be collected by the Committee. Case identification will only be utilized in the review process in order to enlist interagency cooperation. No material may be used for reasons other than that for which it was intended. It is further understood that there may be individual cases reviewed by the Committee which will require that a particular agency be asked to take the lead in addressing a systemic or quality of care issue based on that agency's clear connection with the issue at hand.

Kelly Ayotte — 5/6/05
Attorney General — Date

John A. Stephen — 5/1/05
Commissioner, Health and Human Services — Date

Richard M. Flynn — 4/28/05
Commissioner, Department of Safety — Date

APPENDIX D: CONFIDENTIALITY AGREEMENT

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE CONFIDENTIALITY AGREEMENT

The purpose of the New Hampshire Child Fatality Review Committee is to conduct a full examination of unresolved or preventable child death incidents. In order to assure a coordinated response that fully addresses all systemic concerns surrounding child fatality cases, the New Hampshire Child Fatality Review Committee must have access to all existing records on each child death. This includes social service reports, court documents, police records, autopsy reports, mental health records, hospital or medical related data and any other information that may have a bearing on the involved child and family.

With this purpose in mind, I the undersigned, as a representative of:

_____

agree that all information secured in this review will remain confidential and not be used for reasons other than that which was intended. No material will be taken from the meeting with case identifying information.

_____
Print Name

_____
Authorized Signature

_____
Witness

_____
Date

APPENDIX E: STATUTORY AGREEMENT

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE STATUTORY AUTHORITY

As a condition for receiving funds from the New Hampshire Department of Justice through the Children's Justice Act Grant, administered by United States Department of Health and Human Services, the State of New Hampshire is required to establish a citizen/professional review panel to "evaluate the extent to which the agencies are effectively discharging their child protection responsibilities." The New Hampshire Child Fatality Review Committee meets the criteria for this review process. 42 U.S.C. S1Oba(c)(A). (CAPTA, Child Abuse Prevention & Treatment Act).

The membership is composed of "volunteer members who are broadly representative of the community in which such panel is established, including members who have expertise in the prevention and treatment of child abuse or neglect." 42 U.S.C. 5106a(c)(A)(B).

The 1996 CAPTA amendments require:

The amendments continue the requirement that, to receive funding, a state must have in effect methods to preserve confidentiality of records "in order to protect the rights of the child and of the child's parents or guardians." The persons and entities to which reports and records can be released include:

> (II) Federal, State, or local government entities, or any agent of such entities, having a need for such information in order to carry out its responsibilities under law to protect children from abuse and neglect;
>
> (III) child abuse citizen review panels;
>
> (IV) child fatality review panels;
>
> (V) other entities or classes of individuals statutorily authorized by the State to receive such information pursuant to a legitimate State purpose. (42 USC 5106a(b)(2(A)(v))

Confidentiality provisions prohibit the panel's disclosure "to any person or government official any identifying information about any specific child protection case with respect to which the panel is provided information" or making any other information public unless authorized by state statutes. The amendments further provide that the state shall establish civil penalties for violation of the confidentiality provisions, 42 USC 5106a(c)(4)(B).

APPENDIX F: CASE REVIEW PROTOCOL

1. The Committee will review data regarding all deaths of New Hampshire children up to and including 18 years old.

2. Comprehensive, multidisciplinary review of any specific cases may be initiated by the Department of Justice, the Department of Health and Human Services, the Department of Safety, or by any member of the New Hampshire Child Fatality Review Committee (CFRC).

3. The review process begins with obtaining a list of in-state child deaths from the New Hampshire Department of Health and Human Services and/or from the Office of the Chief Medical Examiner.

   A. The deaths are then sorted by manner of death: natural, homicide, traffic, suicide, and accident other than traffic.

   B. Prior to clinical review, relevant records (e.g.: autopsy reports, law enforcement, Division for Children Youth and Families) are obtained.

   C. Cases may be selected for full Committee review by the Executive Committee from a variety of resources and documents which enumerate children's deaths and their cases from 1994 on.

   D. The review focuses on such issues as:

      - Was the death investigation adequate?
      - Was there access to adequate services?
      - What recommendations for systems changes can be made?
      - Was the death preventable?*

4. After review of all confidential material, the Committee may provide a summary report of specific findings to the Governor and other relevant agencies and individuals.

5. The CFRC will develop periodic reports on child fatalities, which are consistent with state and federal confidentiality requirements.

6. The CFRC will convene at times published.

7. Each CFRC member will have an alternate member from their discipline or agency and will ensure that one member will be present at every meeting.

8. Confidentiality Agreements are required of any individual participating in any CFRC meeting.

9. The CFRC Executive Committee, comprised of members of the CFRC, assesses case information to be reviewed by the CFRC and performs other business as needed.

***WHAT IS A PREVENTABLE DEATH?**

A preventable death is one in which, by retrospective analysis, it is determined that a reasonable intervention (e.g., medical, educational, social, legal or psychological) might have prevented the death. "Reasonable" is defined as taking into consideration the conditions, circumstances, or resources available.

APPENDIX G: LIST OF ICD-10 CODES USED FOR ANALYSIS

Accidental discharge of firearms	W32 - W34
Accidental drowning and submersion	W65 - W74
Accidental exposure to smoke, fire and flames	X00 - X09
Accidental poisoning and exposure to noxious substances	X40 - X49
Acute and rapidly progressive nephritic and nephrotic syndrome	N00 - N01 , N04
Acute and subacute endocarditis	I33
Acute bronchitis and bronchiolitis	J20 - J21
Acute myocardial infarction	I21 - I22
Acute poliomyelitis	A80
Acute rheumatic fever and chronic rheumatic heart diseases	I00 - I09
Alcoholic liver disease	K70
All other and unspecified malignant neoplasms	C17 , C23 - C24 , C26 - C31 , C37 - C41 , C44
All other diseases (Residual)	D65 - E07 , E15 - E34 , E65 - F99 , G04 - G12
All other forms of chronic ischemic heart disease	I20 , I25.1 - I25.9
All other forms of heart disease	I26 - I28 , I34 - I38 , I42 - I49 , I51
Alzheimer's disease	G30
Anemias	D50 - D64
Aortic aneurysm and dissection	I71
Arthropod-borne viral encephalitis	A83 - A84 , A85.2
Assault (homicide) by discharge of firearms	X93 - X95
Assault (homicide) by other and unspecified means and their sequela	U01-U02 , X85 - X92 , X96 - Y09 , Y87.1
Asthma	J45 - J46
Atherosclerosis	I70
Atherosclerotic cardiovascular disease, so described	I25.0
Bronchitis, chronic and unspecified	J40 - J42
Cerebrovascular diseases	I60 - I69
Certain conditions originating in the perinatal period	P00 - P96
Certain other intestinal infections	A04 , A07 - A09
Cholelithiasis and other disorders of gallbladder	K80 - K82
Chronic glomerulonephritis, nephritis and nephritis not specified as acute or chronic, and renal sclerosis unspecified	N02 - N03 , N05 - N07 , N26
Complications of medical and surgical care	Y40 - Y84 , Y88
Congenital malformations, deformations and chromosomal abnormalities	Q00 - Q99
Diabetes mellitus	E10 - E14
Discharge of firearms, undetermined intent	Y22 - Y24
Diseases of appendix	K35 - K38
Diseases of pericardium and acute myocarditis	I30 - I31 , I40
Emphysema	J43
Essential (primary) hypertension and hypertensive renal disease	I10 , I12
Falls	W00 - W19
Heart failure	I50
Hernia	K40 - K46
Hodgkin's disease	C81

Human immunodeficiency virus (HIV) disease	B20 - B24
Hyperplasia of prostate	N40
Hypertensive heart and renal disease	I13
Hypertensive heart disease	I11
In situ neoplasms, benign neoplasms and neoplasms of uncertain or unknown behavior	D00 - D48
Infections of kidney	N10 - N12 , N13.6 , N15.1
Inflammatory diseases of female pelvic organs	N70 - N76
Influenza	J10 - J11
Intentional self-harm (suicide) by discharge of firearms	X72 - X74
Intentional self-harm (suicide) by other and unspecified means and their sequelae	U03 , X60 - X71 , X75 - X84 , Y87.0
Legal intervention	Y35 , Y89.0
Leukemia	C91 - C95
Malaria	B50 - B54
Malignant melanoma of skin	C43
Malignant neoplasm of bladder	C67
Malignant neoplasm of breast	C50
Malignant neoplasm of cervix uteri	C53
Malignant neoplasm of esophagus	C15
Malignant neoplasm of larynx	C32
Malignant neoplasm of ovary	C56
Malignant neoplasm of pancreas	C25
Malignant neoplasm of prostate	C61
Malignant neoplasm of stomach	C16
Malignant neoplasms of colon, rectum and anus	C18 - C21
Malignant neoplasms of corpus uteri and uterus, part unspecified	C54 - C55
Malignant neoplasms of kidney and renal pelvis	C64 - C65
Malignant neoplasms of lip, oral cavity and pharynx	C00 - C14
Malignant neoplasms of liver and intrahepatic bile ducts	C22
Malignant neoplasms of meninges, brain and other parts of central nervous system	C70 - C72
Malignant neoplasms of trachea, bronchus and lung	C33 - C34
Malnutrition	E40 - E46
Measles	B05
Meningitis	G00 , G03
Meningococcal infection	A39
Motor vehicle accidents	V02 - V04 , V09.0 , V09.2 , V12 - V14 , V19.0 -
Multiple myeloma and immunoproliferative neoplasms	C88 , C90
Non-Hodgkin’s lymphoma	C82 - C85
Operations of war and their sequelae	Y36 , Y89.1
Other acute ischemic heart diseases	I24
Other and unspecified events of undetermined intent and their sequelae	Y10 - Y21 , Y25 - Y34 , Y87.2 , Y89.9
Other and unspecified infectious and parasitic diseases and their sequelae	A00 , A05 , A20 - A36 , A42 - A44 , A48 - A
Other and unspecified malignant neoplasms of lymphoid, hematopoietic, and related tissue	C96
Other and unspecified nontransport accidents and their sequelae	W20 - W31 , W35 - W64 , W75 - W99 , X10 - X

Other chronic liver disease and cirrhosis	K73 - K74
Other chronic lower respiratory diseases	J44 , J47
Other complications of pregnancy, childbirth and the puerperium	O10 - O99
Other diseases of arteries, arterioles and capillaries	I72 - I78
Other diseases of respiratory system	J00 - J06 , J30 - J39 , J67 , J70 - J98
Other disorders of circulatory system	I80 - I99
Other disorders of kidney	N25 , N27
Other land transport accidents	V01 , V05 - V06 , V09.1 , V09.3 - V09.9 , V10 -
Other nutritional deficiencies	E50 - E64
Other tuberculosis	A17 - A19
Parkinson's disease	G20 - G21
Peptic ulcer	K25 - K28
Pneumoconioses and chemical effects	J60 - J66 , J68
Pneumonia	J12 - J18
Pneumonitis due to solids and liquids	J69
Pregnancy with abortive outcome	O00 - O07
Renal failure	N17 - N19
Respiratory tuberculosis	A16
Salmonella infections	A01 - A02
Scarlet fever and erysipelas	A38 , A46
Septicemia	A40 - A41
Shigellosis and amebiasis	A03 , A06
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	R00 - R99
Syphilis	A50 - A53
Unspecified acute lower respiratory infection	J22
Viral hepatitis	B15 - B19
Water, air and space, and other and unspecified transport accidents and their sequelae	V90 - V99 , Y85
Whooping cough	A37